CHAPTER III: OUTPATIENT CODE EDITOR MODIFICATIONS

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OBJECTIVE

Understand the function of the revised OCE in the processing of OPPS claims.

OUTPATIENT CODE EDITOR

The Outpatient Code Editor (OCE) is a software package supplied to the intermediary by the Health Care Financing Administration (HCFA). Historically, the OCE edited outpatient hospital claims to detect incorrect billing data and determine if the Ambulatory Surgery Center (ASC) limit should apply to each claim. The OCE also reviewed each HCPCS and ICD-9-CM code for validity and coverage.

With the implementation of the Outpatient Prospective Payment (OPPS), the OCE will have a central role in processing claims paid under this system. The following types of claims will be edited by the OCE as part of OPPS:

- All outpatient Part B claims (bill types 12x, 13x, or 14x) with the exception of Indian Health Services and critical access hospital bills

- Community mental health center (CMHC) claims (bill type 76x)

- Comprehensive outpatient rehabilitation facility (CORF) claims containing specific HCPCS codes for vaccines (bill type 75x)

- Home health agency (HHA) claims containing specific HCPCS codes for antigens, vaccines, splints, and casts (bill type 34x)

- Any claim containing condition code 07 with certain HCPCS codes for antigens, vaccines, splints, and casts

Other outpatient claims, with the exception of Indian Health Services hospital claims, may be passed through the OCE for purposes of editing diagnosis and line item information to identify coding errors.

The two main functions of the revised OCE are:

- Editing of claim data to identify errors and identifying claim and line dispositions

- Assigning of Ambulatory Patient Classification (APC) number for each service covered under OPPS and return information to be used as input to the OPPS Pricer

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Claims processed by OCE
- **Outpatient**
- **CMHC**
- **CORF**
- **HHA**
- **Condition code 07**

Main functions of OCE
- **Edit claims**
- **Assign payment information**

New capabilities

- **Claims for more than one day**
- **Edit based on bill type**
- **Additional edits**
- **Identify disposition**
- **Compute payment information**
- **Assign flags**

In order to accommodate these functions, the OCE will now:

- Process claims that span more than one date of service

- Selectively edit claims based on type of bill and other criteria

- Edit claims using additional parameters

- Identify a disposition based on the OCE edits

- Compute information on OPPS services to be used for payment

- Assign flags to communicate editing, disposition, and payment information

The previous versions of the OCE focused solely on the presence or absence of certain edits, but did not specify what action should be taken when an edit occurred. The new structure links actions to be taken, the reasons for the actions, and the information on the claim that caused the action. Also, the previous version of the OCE also did not give any information related to payment.

OCE handles claims spanning more than one date of service by subdividing the claim into separate days for the purpose of determining discounting and multiple visits on the same calendar day. However, in order to properly apply an APC, emergency room and observation room services will be reviewed as one date of service even if the service spans more than one day. The span of time that a claim represents is controlled by the "from" and "through" dates of the claim. All applicable services must be on a single claim since APC assignment and some edits are date dependent. For example, a bilateral procedure error will occur if a pair of procedures were billed for the same date of service, but not if the dates of service are different.

In general, the OCE performs all functions that require specific reference to HCPCS codes, HCPCS modifiers, and ICD-9-CM diagnosis codes.

INFORMATION SENT TO THE OCE

The version of the OCE to be used will be established using the "from" date of the claim. All applicable services must be organized into one claim record and passed as a unit to the OCE. Both claim and line item information is passed to the OCE.

The following claim information is sent to the OCE:

OCE input from claim

- "From" and "through" dates
- Condition codes
- ICD-9 diagnosis codes
- Age
- Sex
- Type of bill
- Medicare provider number

The following line information will also be input to the OCE:

- HCPCS code and up to 2 modifiers
- Revenue code
- Service date
- Service units
- Charge

OCE IDENTIFIED DISPOSITIONS

The occurrence of an OCE edit can result in one of six different dispositions. These dispositions will help to assure that intermediaries in various parts of the country are following similar procedures. The dispositions are as follows:

Dispositions
- **Rejection**
- **Denial**
- **Suspension**
- **Return to provider**

- Claim rejection
- Claim denial
- Claim return to provider
- Claim suspension
- Line item rejection
- Line item denial

Claim Rejection

There are one or more edits present to cause the whole claim to be rejected. If the whole claim is rejected, the provider:

- Can correct and resubmit the claim if a data entry error was made.
- Cannot appeal the claim rejection if the data is correct because the service(s) is not covered by Medicare.

Claim Denial

There are one or more edits present that cause the whole claim to be denied. If the whole claim is denied, the provider:

- Cannot resubmit the claim.
- Can appeal the claim denial.

Claim Return to Provider (RTP)

There are one or more edits present that cause the whole claim to be RTP'd. If the claim is RTP'd, the provider:

- Can resubmit the claim after correcting the problems on the claim.

Claim Suspension

There are one or more edits present that cause the whole claim to be suspended. A claim suspension means that the claim is suspended for the intermediary to review. The provider will not receive this disposition.

Line Item Rejection

There are one or more edits present that cause one or more individual line items to be rejected. A line item rejection means the claim can be processed for payment with some lines rejected for payment. If a line item is rejected, the provider:

- Can correct and resubmit the line item(s) if a data entry error was made.
- Cannot appeal the line item rejection(s) if the data is correct because the service(s) is not covered by Medicare.

Line Item Denial

There are one or more edits present that cause one or more individual line items to be denied. A line item denial means the claim can be processed for payment with some line items denied for payment. If a line item was denied, the provider:

- Cannot resubmit the claim/line item(s).
- Can appeal the line item(s) denial.

In the initial release of the revised OCE, many of the edits have a disposition of RTP to allow providers time to adapt to OPPS. In subsequent releases of OCE, the disposition of some edits may change.

OCE EDITS

There are now 41 different OCE edits. Correct coding initiative (CCI) edits and unit of service edits are included in the revised OCE. Edits can be applied prepayment or post-payment.

OCE edits

This section contains descriptions of the OCE edits. Each edit has a number in parenthesis that corresponds with the chart at the end of this section. This chart, *OCE Edits and Disposition of Claims*, can be used to help resolve OCE related issues. It identifies the OCE edit, the OCE identified disposition, and the action required by the provider.

The provider will not see the OCE edits, but will receive a reason/error code related to an OCE edit. Reason/error codes are set by the standard systems. Although the same information will be communicated by these codes, the description of the codes may contain different wording than that in the OCE edit.

Already Existing Edits

The revised OCE contains edits that were in place in prior versions of the OCE. Claims will continue to be subject to these edits.

- Invalid diagnosis code **(1)**

The OCE checks each diagnosis code against a table of valid ICD-9-CM diagnosis codes for the time period shown on the claim. If the reported code is not in these tables, the code is considered invalid. All valid ICD-9-CM codes are listed in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volume 1 & 2 (Diseases).

The OCE also edits for a complete diagnosis code. If a diagnosis code is on a claim without a required fourth or fifth digit, it is considered invalid.

- Diagnosis and age conflict **(2)**

The OCE detects inconsistencies between a patient's age and any diagnosis on the claim. For example, a five-year-old patient with benign prostatic hypertrophy is clinically unreasonable. Therefore, either the diagnosis or age is presumed to be incorrect.

- Diagnosis and sex conflict **(3)**

The OCE detects inconsistencies between a patient's sex and any diagnosis on the claim. An example of a sex conflict is a male patient with cervical cancer. The diagnosis conflicts with the sex of the patient; therefore, either the patient's diagnosis or sex is incorrect.

Already existing edits
- **Invalid diagnosis code**
- **Diagnosis and age conflict**
- **Diagnosis and sex conflict**

Already existing edits (cont'd)
- **E-Code as reason for visit**
- **Invalid procedure code**
- **Procedure and sex conflict**
- **Non-covered service**
- **Questionable covered procedure**

- E-Code as reason for visit **(5)**

E-codes are ICD-9 diagnosis codes that begin with an E. They describe the circumstances that caused an injury, not the nature of the injury, and therefore, are not accepted by OCE as a principal diagnosis.

- Invalid procedure code **(6)**

The OCE checks each HCPCS procedure code against a table of valid HCPCS codes for the time period shown on the claim. If the reported code is not in this table, the code is considered invalid. Valid HCPCS codes are listed in the Current Procedural Terminology, 4th Edition, published by the American Medical Association. Some national codes from the Health Care Financing Administration's Common Procedure Coding System (HCPCS) Level II codes are also included for services not described by CPT codes.

- Procedure and sex conflict **(8)**

The OCE detects inconsistencies between a patient's sex and any HCPCS procedure code on the claim. An example of a sex conflict is a male patient reported to have had a dilation and curettage (D &C). Since the procedure conflicts with the sex of the patient, either the patient's sex or the procedure is incorrect.

- Non-covered service **(9)**

The OCE identifies services that are never paid under the Medicare program. Examples of non-covered services are radial keratotomy, hearing aid exam, and preventive visit. Non-covered services are assigned status indicator "E" in Addendum B of the OPPS final rule.

- Questionable covered procedure **(12)**

The OCE identifies procedures that are only covered by the Medicare program under certain medical circumstances. For example, HCPCS 11920, "Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less" is not covered when performed for cosmetic purposes. However if it were done subsequent to a burn, it might be covered.

• Invalid date **(23)**

The OCE checks the dates on the claim for validity. This edit occurs if there is no date on the claim or if the date is not within the normal calendar range. The date 033200 is invalid since there are not thirty-two days in March.

• Date out of OCE range **(24)**

The OCE checks the "from" date of the claim and applies this edit if the dates of service are prior to July 1, 1987. The OCE was not established until this date. This edit is used to assist internal intermediary operations.

• Invalid age **(25)**

If the age reported is not between 0 years and 124 years, the OCE assumes the age is in error. If the beneficiary's age is established at over 124, it must be re-entered as 123.

• Invalid sex **(26)**

The sex code reported must be either "M" for male or "F" for female. If anything else is entered on the claim, it is invalid.

The rest of the edits are new for the OCE and new to intermediary claim processing.

Edits for Non-Covered Services

Non-covered service submitted for verification of denial (Condition Code 21) **(10)**

The OCE identifies claims billed by a provider for a denial notice and flag the claim for denial. This will assure that payment is not made by the OPPS Pricer.

Non-covered services
• **Non-covered service submitted for verification of denial (CC 21)**
• **Non-covered service submitted for review (CC 20)**
• **Additional payment for services not provided by Medicare**

• Non-covered service submitted for review (Condition Code 20) **(11)**

The OCE identifies non-covered claims billed by a provider when a beneficiary requests a Medicare determination, and suspends them for intermediary action.

- Additional payment for services not provided by Medicare **(13)**

The OCE detects codes that are not reportable to Medicare, but may be reportable to other insurers. These codes will now pass through the intermediary claim system, but will not be paid. Historically, the provider has not been allowed to submit these codes. Non-reportable codes are assigned status indicator "E" in Addendum B of the OPPS Final Rule.

Edit for Inpatient Services

Inpatient services
- **Inpatient procedure**

- Inpatient procedure **(18)**

HCFA has established a list of procedures that are excluded from OPPS and are paid by Medicare only when performed in an inpatient setting. Performing these procedures in an outpatient setting is considered not reasonable and necessary. OCE identifies these procedures when they are billed on an outpatient claim. Inpatient procedures are listed in Addendum E of the OPPS Final Rule. In addendum B of the OPPS Final Rule, these procedures are assigned status indicator "C."

Edit for Incidental Service

Incidental services
- **Only incidental services reported**

- Only incidental services reported **(27)**

The OCE determines if the only items billed on a date of service are incidental services, for example anesthesia or supplies. Under OPPS, these services are packaged and only reimbursed as part of the service/procedure performed. Incidental services are assigned status indicator "N" in Addendum B of the OPPS Final Rule.

Edits for Invalid Data Elements

- Invalid modifier **(22)**

The OCE checks each modifier against a table of valid modifiers for the time period shown on the claim. If the reported modifier is not in this table, it is considered invalid. Valid modifiers are listed in the Current Procedural

Invalid data elements
- **Invalid modifier**
- **Invalid revenue code**
- **Procedure and age conflict**
- **Code indicates a site of service not included in OPPS**
- **Code not recognized by Medicare; alternate code for same service available**

Terminology, 4th Edition, published by the American Medical Association. Level II modifiers from the Health Care Financing Administration's Common Procedure Coding System (HCPCS) Level II book are also included.

While all of the modifiers listed will be accepted by OCE, the only modifiers specifically approved for outpatient hospital use are listed in the billing section of this manual.

- Invalid revenue code **(41)**

The OCE checks each revenue code against a table of valid revenue codes for the time period shown on the claim. If the reported revenue code is not in this table, it is considered invalid. Valid revenue codes are those approved by the National Uniform Billing Committee (NUBC) for use on the UB-92 claim form, or a comparable electronic format.

Not all valid revenue codes are appropriate for Medicare billing. Providers should consult their HCFA provider manual for billable revenue codes.

- Procedure and age conflict **(7)**

The OCE detects inconsistencies between a patient's age and any HCPCS procedure code on the claim. For example, it is clinically impossible for seventy-eight year old women to deliver a baby. Therefore, either the procedure or age is incorrect.

- Code indicates a site of service not included in OPPS **(14)**

The OCE edits for HCPCS codes that describe services not performed in the provider's setting. An example is HCPCS 99321, "Domiciliary or rest home visit for the evaluation and management of a new patient…" These codes were contained in a different edit of the original OCE. They are assigned status indicator "E" in Addendum B of the OPPS final rule.

- Code not recognized by Medicare; alternate code for same service available **(28)**

The OCE identifies codes that are not reportable to Medicare because Medicare requires that an alternate code, usually a

Level II HCPCS code, be used. These codes were formerly part of an OCE edit called non-reportable procedures. These HCPCS codes are assigned status indicator "E" in Addendum B of the OPPS final rule.

Edits for Units of Service

- Service unit out of range for procedure **(15)**

The OCE edits the claim to identify number of units that are clinically impossible or unreasonable for the service billed. All line items with the same HCPCS code on the same date of service will be added together when this edit is applied. The unit of service edit is discussed in more detail later in this section.

- Terminated bilateral procedure or terminated procedure with units greater than one **(37)**

The OCE identifies lines where a terminated procedure contains modifier 52 or has units greater than one. This reflects incorrect billing. When a procedure is terminated, the first procedure that was planned should be reported with the appropriate modifier (73 or 74). Any other procedure is not reported. Refer to the billing section of this manual for more information on these modifiers.

Edits Based on HCPCS and Modifiers

- Mutually exclusive procedure that is not allowed even if an appropriate modifier is present **(19)**

The OCE uses CCI edits to identify mutually exclusive procedures. Mutually exclusive procedures are those that cannot be performed during the same session. This edit will identify procedures that are always mutually exclusive. These procedures would never be performed on the same day.

For example, HCPCS codes 44950, "Appendectomy" and 44970, "Laporoscopy, surgical, appendectomy" can never be done on the same day. An appendix can only be removed by one method, either by open incision or by laparoscopy; and

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Units of service
- **Service unit out of range for procedure**
- **Terminated bilateral procedure or terminated procedure with units greater than one**

HCPCS and modifiers
- **Mutually exclusive procedure that is not allowed even if an appropriate modifier is present**

since each person has only one appendix, it can only be removed once.

- Mutually exclusive procedure that would be allowed if appropriate modifier were present **(39)**

The OCE uses CCI edits to identify procedures that are mutually exclusive unless billed with a modifier to explain the circumstances.

For example, HCPCS 43760, "Change of gastrostomy tube'" would not be performed during the same operative session as HCPCS 43750, "Percutaneous placement of gastrostomy tube." However, the patient may have developed complications later that day and so the patient was returned to the operating room in order that HCPCS 43760 be performed. Therefore, HCPCS 43760 should be billed with modifier 78 to indicate a return to the operating room for a related procedure during the postoperative period.

- Component of a comprehensive procedure that is not allowed even if an appropriate modifier is present **(20)**

The OCE uses CCI edits to identify components of a procedure that are billed on the same date of service as the comprehensive procedure. Services that are normally part of a procedure cannot be billed separately, but rather are considered to be included in the code for the more comprehensive procedure. This edit will identify procedures that are always components of the comprehensive procedure and should never be billed with it.

HCPCS code 58120, "Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)" and 57800, "Dilation of uterine cervix, instrumental (separate procedure)" can never be billed together, because 57800 would be performed, if necessary, as part of 58120.

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HCPCS and modifiers (cont'd)
- **Component of a comprehensive procedure that would be allowed if appropriate modifier were present**
- **Multiple bilateral procedures without modifier 50**
- **Inappropriate specification of bilateral procedure**

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- Component of a comprehensive procedure that would be allowed if appropriate modifier were present **(40)**

The OCE detects components of a procedure that are billed on the same date of service as the comprehensive procedure. This edit identifies procedures that could possibly be billed together if a modifier was present on one of the procedures.

For example, if a biopsy is done with an excision of a lesion, a separate HCPCS code cannot be reported for the biopsy. If HCPCS code 25065, "Biopsy, soft tissue of forearm and/or wrist; superficial" and HCPCS code 25075, "Excision, tumor, forearm and/or wrist area; subcutaneous" were billed on the same date of service, 25065 would not receive additional payment because it is included in the payment for 25075. However, if procedure 25065 were billed with modifier RT and procedure 25075 were billed with modifier LT, additional payment would be made because the modifier would explain that a separate procedure had been performed.

- Multiple bilateral procedures without modifier 50 **(16)**

The OCE identifies HCPCS codes that can be performed bilaterally when the code is billed on more than one line for a single date of service if modifier 50 is not on any of the lines. Modifier 50 is defined as "bilateral procedure." Refer to the billing section of this manual for additional information on this modifier.

For example, if the physician performed HCPCS 25066 (Biopsy, soft tissue of forearm and/or wrist; deep) on both the right and left wrist, 25066 should not be on two lines. The correct way to bill the biopsy is on one line with 2506650.

- Inappropriate specification of bilateral procedure **(17)**

The OCE identifies HCPCS codes that can be performed bilaterally if the code is billed on more than one line for the same date of service when all or some lines include modifier 50.

An example claim might have three lines with HCPCS 29821 (Arthroscopy, shoulder, surgical; synovectomy, complete) 29821 on one line, 2982150 on another line, and 2982150

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on a third line. This is incorrect billing and reflects improper use of modifier 50. Refer to the billing section of this manual for information on this modifier.

This edit will also identify when a procedure with "bilateral" in its HCPCS definition is billed on more than one line.

- Medical visit on the same day as a type "T" or "S" procedure without modifier 25 **(21)**

The OCE detects when an evaluation and management (E & M) code is billed on the same day as a type S (significant procedure) or T (surgical service to which multiple procedure payment reduction applies) procedure. E & M codes are not normally reimbursed on the same day as surgery or significant procedures. Care given before and after the procedure that is associated with the procedure is not separately billable. Refer to the billing section of this manual for additional information on modifier 25. This edit applies to procedures that are identified by a T or S in Addendum B of the OPPS Final Rule.

- Multiple medical visits on the same day with the same revenue code without condition code G0 **(42)**

If multiple medical visits, i.e., evaluation and management services, are billed with the same revenue code for the same date of service, only the line with the highest APC payment will be considered for payment.

Visits with more than one professional and multiple visits with the same professional, that take place during the same session at a single location within the hospital, constitute a single visit. Therefore, when the revenue center is the same, condition code G0 is required to indicate that a separate visit was made on the date of service in question. Refer to the billing section of this manual for more information on this condition code.

- Inconsistency between implanted device and implantation procedure **(38)**

The OCE identifies claims where the implanted device does not match the type of procedure performed. It would be inconsistent if a claim had HCPCS code 65130, "Insertion of ocular implant secondary; after evisceration, in scleral shell"

billed with HCPCS V2630, "Anterior chamber intraocular lens." Either the procedure or the implant was billed incorrectly.

Partial Hospitalization Edits

The partial hospitalization (PHP) edits will only be applied to CMHC claims (bill type 76x) and outpatient hospital claims containing condition code 41 (partial hospitalization). The OCE will determine that, for each date of service, appropriate codes are identified and that the services reflect the intensive nature of a partial hospitalization program. Claims that include days that do not pass these edits will be identified for medical review.

This information, as well as guidance provided in the OPPS Final Rule and OCE PM A-00-21, was intended to help providers understand when claims will be identified for medical review. This information was not intended to describe how a day of partial hospitalization should look. The PHP APC per diem payment reflects an average day of PHP. It is expected that most patients on many days will receive more intensive services than reflected in the OCE PHP edits.

- Partial hospitalization service for non-mental health diagnosis **(29)**

The OCE edits a partial hospitalization claim for a mental health diagnosis. Partial hospitalization claims must include a mental health diagnosis since these programs are for patients who have profound and disabling mental health conditions.

- Insufficient services on day of partial hospitalization **(30)**

Partial hospitalization programs are designed to provide individualized, coordinated, comprehensive, and multidisciplinary treatment program. The OCE identifies a date of service on a claim that:

- Does not have a psychotherapy code
- Contains less than three partial hospitalization HCPCS codes

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Partial hospitalization
- **PHP service for non-mental health diagnosis**
- **Insufficient services on day of PHP**
- **PHP on same day as ECT or type T procedure**

This edit will suspend claims for one date of service.

- Partial hospitalization on same day as electroconvulsive therapy (ECT) or type T procedure **(31)**

The OCE identifies dates of service on a claim where the patient has received ECT or a surgical service on the same day as partial hospitalization services. This edit suspends claims for one date of service.

For example, if both outpatient surgery and partial hospitalization are billed on the same day, it may be that one of the services is billed incorrectly. If both services were rendered, the claim will be reviewed to determine if the partial hospitalization day is reasonable and necessary, taking into account the patient's condition.

- Partial hospitalization claim spans three or less days with insufficient services, or electroconvulsive therapy or significant procedure on at least one of the days **(32)**

This edit combines edits (30) and (31) for partial hospitalization claims with "from" and "through" dates spanning two or three dates of service. The OCE detects that ECT or a procedure is billed on the same day as partial hospitalization services, or that a low intensity of services is billed. See explanation above.

- Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services **(33)**

Because partial hospitalization is provided in lieu of inpatient psychiatric care, patients require an intensive treatment program. The OCE determines if a claim whose "from" and "through" dates span more than three days is billed with less than four out of seven days containing partial hospitalization services.

- Partial hospitalization claim spans more than three days with insufficient number of days meeting partial hospitalization criteria **(34)**

This edit combines edits (30) and (31) for partial hospitalization claims with "from" and "through" dates spanning more than three days. It will determine if the claim

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Partial hospitalization (cont'd)

- **PHP claim spans three or less days with insufficient services, or ECT or significant procedure on at least 1 of the days**
- **PHP claim spans more than 3 days with insufficient number of days having mental health services**
- **PHP claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria**

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as a whole reflects an intensity of services expected in a partial hospitalization program.

Partial hospitalization is also discussed in the billing and clinical sections of this manual.

Outpatient Psychiatric Services Edits

These edits will apply to outpatient psychiatric services billed by a hospital when condition code 41 (partial hospitalization) **is not** on the claim.

Outpatient psychiatric services
- **Only activity therapy and/or OT services provided**
- **Extensive mental health services provided on day of ECT or significant procedure**

- Only activity therapy and/or occupational therapy services provided **(35)**

Occupational therapy (OT) is covered when it is part of an overall active treatment plan for a patient with a diagnosed psychiatric illness. Outpatient psychiatric treatment programs that consist entirely of activity therapy (AT) are not covered. The OCE applies this edit to claims for outpatient hospital psychiatric services when AT or OT are the **only** services billed. The claim will not be selected by this edit if AT or OT is billed on the same day as other outpatient hospital psychiatric services.

The PHP HCPCS codes for AT and OT should not be used for outpatient psychiatric services. These codes are only for use in PHP. AT is billed with revenue code 904 and no HCPCS code, and OT is billed with codes in the CPT Physical Medicine and Rehabilitation range.

- Extensive mental health services provided on day of electroconvulsive therapy or significant procedure **(36)**

The OCE identifies dates of service on an outpatient psychiatric services claim where the patient has received ECT or a procedure on the same day they received extensive mental health services. This edit is similar to partial hospitalization edit number (31), but applies to non-partial hospitalization claims.

For example, if outpatient surgery and three mental health therapy groups are billed on the same day, it may be that some of the services are billed incorrectly. If all the services were rendered, the claim will be reviewed to determine they are reasonable and necessary.

OCE EDITS AND DISPOSITION OF CLAIMS

EDIT #	OCE EDIT	DISPOSITION	PROVIDER ACTION
1	Invalid diagnosis code	RTP	- Review diagnosis code for keying error. - Refer to current edition of ICD-9-CM manual for valid code. - Refer to current edition of ICD-9-CM manual to see if a 4th or 5th digit is required. - Correct and resubmit claim.
2	Diagnosis and age conflict	RTP	- Review diagnosis codes and age for keying error. - Verify data billed against patient records. - Correct and resubmit claim.
3	Diagnosis and sex conflict	RTP	- Review diagnosis codes and sex for keying error. - Verify data billed against patient record. - Correct and resubmit claim.
5	E-code as reason for visit	RTP	- E-Code cannot be used as primary diagnosis. - Review patient information for diagnosis related to procedure/service. - Correct and resubmit claim.

6	Invalid procedure code	RTP	- Review HCPCS codes for keying error. - Refer to current CPT and HCPCS Level II books for valid HCPCS code. - Correct and resubmit claim.
7	Procedure and age conflict	RTP	- Review procedure codes and age for keying error. - Verify data billed against patient record. - Correct and resubmit claim.
8	Procedure and sex conflict	RTP	- Review procedure codes and sex for keying error. - Verify data billed against patient record. - Correct and resubmit claim.
9	Non-covered service	Line item denial	- May appeal the line denial.
10	Non-covered service submitted for verification of denial (condition code 21)	Claim denial	- No provider action indicated.
11	Non-covered service submitted for review (condition code 20)	Suspend	- Claim review by intermediary. - No provider action indicated.
12	Questionable covered service	Suspend	- Claim review by intermediary. - No provider action indicated.
13	Additional payment for services not provided by Medicare	Line item rejection	- Review claim for keying error. - If keying error was made, correct and resubmit as claim adjustment.
14	Code indicates a site of service not included in OPPS	RTP	- Review HCPCS codes for keying error. - Verify procedure coded against patient record to determine correct code. - Correct and resubmit claim.

15	Service unit out of range for procedure	RTP	- Review claim for keying error. - Verify units billed against patient record. - Correct and resubmit claim.
16	Multiple bilateral procedure without modifier 50	RTP	- Review correct coding of bilateral procedures. - If specific procedure was done bilaterally, resubmit claim with HCPCS and modifier 50 on one line.
17	Inappropriate specification of bilateral procedure	Line item rejection	- No provider action indicated – one line of HCPCS code with modifier 50 or of procedure with bilateral in the HCPCS code definition is paid, giving full reimbursement for the bilateral procedure.
18	Inpatient procedure	Claim denial	- May appeal the claim denial.
19	Mutually exclusive procedure that is not allowed even if appropriate modifier is present	Line item rejection	- Review HCPCS for keying error. - If keying error was made, correct and resubmit as claim adjustment.
20	Component of a comprehensive procedure that is not allowed even if appropriate modifier is present	Line item rejection	- Review HCPCS codes for keying error. - If keying error was made, correct and resubmit as claim adjustment.
21	Medical visit on same day as a type T or S procedure without modifier 25	Line item rejection	- Review coding guidelines for modifier 25. - If claim was coded incorrectly, correct and resubmit as claim adjustment.
22	Invalid modifier	RTP	- Review modifiers for keying error. - Refer to current CPT and HCPCS Level II books for valid modifiers. - Correct and resubmit claim.
23	Invalid date	RTP	- Review dates on claim for keying error. - Correct and resubmit claim.
24	Date out of OCE range	Suspend	- No provider action indicated.

25	Invalid age	RTP	- Review age for keying error. - If patient is older than 124, report age as 123. - Correct and resubmit claim.
26	Invalid sex	RTP	- Review sex code for keying error. - Sex code must be "M" (male) or "F" (female). - Correct and resubmit claim.
27	Only incidental services reported	RTP	- Review patient record to determine service/procedure rendered. - Resubmit claim with service/procedure included if appropriate.
28	Code not recognized by Medicare; alternate code for same service available	RTP	- Review HCPCS codes on claim against Medicare provider manual and intermediary bulletins. Often a Level II code is required instead of a CPT code. - Correct and resubmit claim.
29	Partial hospitalization service for non-mental health diagnosis	RTP	- Review diagnosis codes for keying errors. - Review patient records to determine primary diagnosis for psychiatric services. - Correct and resubmit claim.
30	Insufficient services on day of partial hospitalization	Suspend	- Claim review by intermediary. - No provider action indicated.
31	Partial hospitalization on same day as electroconvulsive therapy or type T procedure	Suspend	- Claim review by intermediary. - No provider action indicated.
32	Partial hospitalization claim spans 3 or more days with insufficient services, or electroconvulsive or significant procedure on at least one of the days	Suspend	- Claim review by intermediary. - No provider action indicated.

33	Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services	Suspend	- Claim review by intermediary. - No provider action indicated.
34	Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria	Suspend	- Claim review by intermediary. - No provider action indicated.
35	Only activity therapy and/or occupational therapy services provided	RTP	- Review patient record to determine other services rendered. - If appropriate, correct and resubmit claim with other services included.
36	Extensive mental health services provided on day of electroconvulsive therapy or significant procedure	Suspend	- Claim review by intermediary. - No provider action indicated.
37	Terminated bilateral procedure or terminated procedure with units greater than one	RTP	- Review units for keying error. - Review coding instructions for terminated procedure modifiers (73 or 74). Units should never be greater than one. - Correct and resubmit claim.
38	Inconsistency between implanted device and implantation procedure	RTP	- Review HCPCS codes for keying error. - Verify data billed against patient record. - Correct and resubmit claim.
39	Mutually exclusive procedure that would be allowed if appropriate modifier were present	Line item rejection	- Review HCPCS for keying error. - Review coding guidelines for modifiers. - If claim was coded incorrectly, correct and resubmit as claim adjustment.

40	Component of a comprehensive procedure that would be allowed if appropriate modifier were present	Line item rejection	- Review HCPCS for keying error. - Review coding guidelines for modifiers. - If claim was coded incorrectly, correct and resubmit as claim adjustment.
41	Invalid revenue code	RTP	- Review revenue codes for keying error. - Refer to current NUBC standards for valid revenue codes. - Correct and resubmit claim.
42	Multiple medical visits on same day with same revenue code without condition code G0	Line item rejection	- Review claim for keying error. - Review coding guidelines for G0 modifier. - If claim was coded incorrectly, correct and resubmit as claim adjustment.

CORRECT CODING INITIATIVE EDITS

All current CCI edits will be incorporated in the OCE with the exception of anesthesiology edits. The proprietary edits have not been included. CCI edits are applied to claims from the same provider for an individual beneficiary for the same date of service. There are two major types of coding situations.

Correct Coding Initiative
- **Comprehensive/ component edits**
- **Mutually exclusive edits**
- **CCI manual**

- Comprehensive/component edits (20, 40)

These edits are applied to HCPCS code combinations where one of the codes is a component of the more comprehensive code. In this instance, only the comprehensive code is paid.

- Mutually exclusive edits (19, 39)

These edits apply to HCPCS code combinations where one of the codes is considered to be either impossible or improbable to be performed with the other code. Other types of unacceptable code combinations are also included. For example, a code combination consists of one code representing a service "with" something and the other code is the same service "without" something. This edit pays the lower priced service.

Other unacceptable code combinations are also included. For an example, it is not acceptable to bill a HCPCS code for magnetic resonance imaging (MRI) of the brain, one code for an MRI without contrast (70551) and an second HCPCS code for an MRI with contrast (70552). In this case, a different HCPCS code is available that describes an MRI of the brain without contrast followed by contrast material and further sequences (70553).

Correct Coding Initiative Manual

The National Technical Information Service (NTIS) is the only distributor of the Correct Coding Initiative Manual. A subscription service can be ordered through NTIS by calling the NTIS Subscription Department at 1-800-363-2068. To order a single issue of the manual or of a chapter, call the NTIS Sales Desk at 1-800-553-6847.

UNITS OF SERVICE EDITS

| Units of service logic |

The OCE contains a series of units of service edits. These edits are specific to the type of service billed. The premises used to arrive at a maximum number of units of service are based on:

- Knowledge of human anatomy.

- An understanding of standards of medical/surgical practice utilized in the development of the National Correct Coding initiative.

- Although there are exceptions, only one unit can be billed for most surgical procedures in the CPT code range of 10000 – 69999.

- For codes with descriptions of timed services, the maximum unit of service was based on the upper limit typical for the delivery of the procedure. This methodology was used for Physical Medicine and Rehabilitation codes (97032 – 97039, 97110 – 97140, 97504 – 97770) among others.

- Other timed services, such as critical care, where the service can be provided during a twenty-four hour period, the unit of service were based on a twenty-four hour day.

- No maximum number was identified for codes that describe services that can have a high variability of units of service.

Assumptions were also made with regard to modifiers.

- Level II anatomic modifiers (listed in the billing section of this manual) should be used whenever appropriate to designate the anatomic site of a procedure. Therefore, only one unit can be billed for procedure codes to which these modifiers apply.

- Modifier 50 for bilateral procedure is also assigned one unit.

Due to the nature of some services, they do not have a maximum allowable units of service assigned, for example:

- Drug/injection codes – The unit of service is dependent on the dosage of the drug given and the amount in which it is dispensed.

- HCPCS codes that say, "each additional" or "each" as part of their description – There is a variability of medical conditions for which these codes are allowed.

- Unlisted procedures and HCPCS codes for "services not otherwise classified.

- Laboratory tests submitted with modifier "91" – This modifier indicates that the test was repeated on a different specimen.

- Procedures submitted with modifier "59," "76," or "77".

OCE EDITS BY BILL TYPE

| OCE edits by bill type |

The revised OCE applies edits to claims based on bill type. Refer to the following chart titled, "OCE Edits Applied by Bill Type."

OCE EDITS APPLIED BY BILL TYPES

Provider/Bill Types	Diagnosis/ Procedure Edits (Edits 1-14, 16-18, 28, 38)	Modifier Edits (Edit 22)	CCI Edits (Edits 19, 20, 39, 40)	Unit Edits (Edit 15)	Line Item Date Edits (Edit 23, 24)	Revenue Code Edit (Edit 41)	Age/Sex Edits (Edits 25, 26)	Partial Hosp Edits (Edits 29-34)	APC Edits (Edits 21, 27, 35-36, 42)	APC Return Buffer Filled In
Bill type 12X, 13X or 14X without condition code 41	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Any bill type except 12X, 13X 14X, 34X, 74X, 75X or 76X with condition code 07 and certain HCPCS codes	✓	✗	✗	✓	✗	✓	✓	✗	✗	✓
Bill type 13X with condition code 41	✓	✓	✓	✓	✓	✓	✓	✓	✓ *	✓
Bill type 12X or 14X with condition code 41	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Bill type 76X (CMHC)	✓	✗	✗	✓	✓	✓	✓	✓	✗	✓
Bill type 75X (CORF) with certain HCPCS codes	✓	✗	✗	✓	✗	✓	✓	✗	✗	✓
Bill type 22X, 23X (SNF) without condition code 07	✓	✗	✗	✓	✗	✓	✓	✗	✗	✗
Bill type 74X (OPTs)	✓	✗	✗	✓	✗	✓	✓	✗	✗	✗
Bill type 34X (HHA) with certain HCPCS codes	✓	✗	✗	✓	✗	✓	✓	✗	✗	✓
Any bill type except 12X, 13X, 14X, 34X, 74X, 75X or 76X with condition code 07 and not certain HCPCS codes	✓	✗	✗	✗	✗	✓	✓	✗	✗	✗
Any bill type except 12X, 13X, 14X, 22X, 23X, 34X, 74X, 75X or 76X without condition code 07	✓	✗	✗	✗	✗	✓	✓	✗	✗	✗
Bill type 75X or 34X without certain HCPCS codes	✓	✗	✗	✗	✗	✓	✓	✗	✗	✗

✓ = edits apply   ✓ * = 21, 27, 42 only
✗ = edits do not apply at this time

ASSIGNING OF PAYMENT INFORMATION

The OCE uses the HCPCS codes and modifiers on the claim to assign APCs. An APC will be assigned to each significant procedure or medical visit.

OCE assigns additional information to the line level of the claim to inform Pricer when to apply surgical discounting and additional payment for designated drugs and medical devices.

Assign payment information
- **Surgical discounting**

Surgical Discounting

OCE identifies the following situations so that Pricer will apply surgical discounting to the following situations:

- When more than one type T procedure billed on the same date of service (Status indicator "T" is assigned to HCPCS codes in Addendum B of the OPPS Final Rule to indicate surgical procedures to which the multiple procedure payment reduction applies.),

    - The highest paying APC will not be discounted.

    - All other type T procedure will be discounted 50%.

- A HCPCS code with modifier 73 (terminated prior to anesthesia) will be discounted 50%.

- A type T procedure HCPCS code billed with modifier 50 (bilateral), is similar to billing for two procedures, one performed on the right side, and one on the left side. Therefore, when modifier 50 is billed,

    - If it has the highest paying APC of the type T procedures billed for the same date of service, only one of the procedures (right or left) will be discounted (100% + 50%). This will result in a payment of 150% of the APC.

    - If another type T procedure billed on the same date of service has the highest APC, both procedures (right and left) will be discounted (50% + 50%). This will result in a payment of 100% of the APC.

- A non-type T radiological procedure with a modifier 50 will be identified by the OCE to pay 200% of the APC since surgical discounting does not apply.

Assign payment information (cont'd)
- **Partial hospitalization**
- **Outpatient psychiatric services**

Partial Hospitalization

Partial hospitalization claims are paid on a per diem basis. These claims are identified by condition code 41 (outpatient hospital) or bill type 76x (CMHC). The partial hospitalization per diem APC is not tied to a specific HCPCS code. The partial hospitalization APC will be assigned to only one of the lines on a date of service for each date of service billed.

Hospital Outpatient Psychiatric Services

The total amount payable for psychiatric services furnished in an hospital outpatient department (not partial hospitalization) for an individual for one day is limited to the APC payment amount for partial hospitalization. The costs associated with administering a partial hospitalization program represent the most resource intensive of all outpatient mental health treatment and, therefore, Medicare will not pay more for a day of individual services. It would not be appropriate for a provider to obtain more payment through component billing.

The OCE will assign the daily mental health service APC for any date of service that exceeds the partial hospitalization payment amount and package all the psychiatric services rendered on that day into this APC. The reimbursement for the daily mental health service APC will be no more than the reimbursement for the partial hospitalization APC.

INFORMATION RETURNED FROM THE OCE

Most of the information returned from the OCE is communicated to the standard systems and to Pricer, but is not visible on the claim screens. The only OCE information that is visible is the payment method (e.g., OPPS, lab fee schedule, etc.) for the line item. This information is contained on the new line item screen that went into effect with implementation of claim line expansion (CELIP).

Refer to the OCE Program Memorandum A-00-21 for system specifications related to the OCE.

Edit Information

The following information about OCE edits is returned from the OCE for input to the Pricer:

- Edit return buffer

The edit return buffer lists all of the edit numbers that occur on a claim for each of the following type of OCE edits:

- Diagnosis edits
- Procedure edits
- Modifier edits
- Date edits
- Revenue code edits

These buffers are set up so that their position also communicates the source of the information, i.e., the number of the diagnosis or line item.

- Claim return buffer

The claim return buffer summarizes the edits that occurred on a claim. The following information is provided:

- Six individual dispositions – indicates the presence or absence of edits causing the indicated disposition.
  - ◆ Claim rejection
  - ◆ Claim denial
  - ◆ Claim RTP
  - ◆ Claim suspend

Information returned from the OCE
- **Edit information**

◆ Line item rejection

◆ Line item denial

- Six lists of reasons – edits associated with each of the above dispositions are listed.

- Overall claim disposition – summarizes the status of the claim.

Payment Information

Payment information that is returned from the OCE for input to Pricer is called APC return buffer. The following information is communicated for each line item:

- HCPCS APC – The APC that is assigned to the HCPCS code on the line.

- Payment APC – The APC that will determine payment. For most services, the HCPCS and the payment APC will be the same. However, since partial hospitalization is paid on a per diem basis, there is no single line item for partial hospitalization. Therefore, one of the lines that comprise partial hospitalization for a particular date of service will be assigned the partial hospitalization APC.

- Service indicator – Designates the type of service (significant procedure, medical visit, packaged incidental service, etc.) described by the HCPCS code.

- Payment indicator – Identifies if and how the service is paid under OPPS.

- Discounting factor – Will identify the discounting factor that should be applied to the line item. A safeguard was built into this feature. Terminated bilateral procedures (modifier 50 and 73) and terminated procedures (modifier 73) with units greater than one should not occur. If these are received on a claim, a discounting factor is applied to the service to result in payment for one terminated procedure.

- Line item denial or rejection – Identifies the disposition of the line item.

Information returned from the OCE (cont'd)

- **Payment information**

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- Packaging – Identifies if the HCPCS is packaged.

- Payment adjustment – Indicates if and what kind of a payment adjustment is indicated.

- Type of bill inclusion – Indicates whether the service is paid under OPPS for the type of bill.

- Line item action flag – This flag was included to allow the intermediary to override an OCE line item denial or rejection and allow Pricer to compute payment for that line. It also allows the intermediary to indicate that the line item should be denied or rejected even if there are no OCE edits present.